Additional Treatment Plan (Form)
New Treatment / Treatment Break > 6 Months
(Confidential)

State of California **Treatment Plan** VCGCB-VOC-6025 *(Revised 09-08-06)*	California Victim Compensation and Government Claims Board (Board)

Return Form To: **Victim Compensation Program** **P.O. Box 3036** **Sacramento, CA 95812-3036** Or Your Local Victim/Witness Assistance Center Verification Unit	Claim Number: / Date Form Sent: Victim's Name: Claimant's Name: Incident Date:

This form needs to be completed if this is a new client, or an existing client who has not been in treatment with you for over 6 months, and the client has reached the mental health benefit service limitations noted below and additional treatment is necessary as a direct result of the crime. No payment for the additional sessions will be authorized until the Additional Treatment Plan is reviewed and approved. You will be notified by mail of the result of the review. Further requests for additional treatment will be reviewed and may require additional information. This may include session notes or objective assessments of impairment, which may be needed to evaluate or verify this request for additional treatment.

Mental Health Benefit Service Limitations *(Please check the appropriate box)*

Service Limitation	Client/Patient	Requirements
40 Session Hours	☐ Direct Victim	Complete Entire Treatment Plan
30 Session Hours	☐ Direct Victim of Unlawful Sexual Intercourse *(Penal Code, section 261.5(d))* ***(Not to exceed the statutory $3,000.00 outpatient mental health limit)*** ☐ Surviving parent, sibling, child, spouse, registered domestic partner, or *fiancé (fiancée) of a homicide victim ☐ Derivative Victim that is scheduled to testify as a witness in criminal proceedings related to the qualifying crime **Must have witnessed the crime*	Complete Entire Treatment Plan
	☐ Derivative Minor Victim (minor at the time of the crime) ***(Not to exceed the statutory $3,000.00 outpatient mental health limit)*** ☐ Derivative Victim who was the Primary Caretaker of a Minor Direct Victim at the time of the crime (for up to two primary caretakers)	Complete Questions 1 thru 11 and Questions 24 thru 28 ONLY
15 Session Hours	☐ *Derivative Victim (Adult) *A derivative victim eligible in more than one category may use only the most favorable category	Complete Questions 1 thru 11 and Questions 24 thru 28 ONLY

Session Calculations (Individual/Family Therapy)

Individual/Family:	Session Hour = 1 Session	Group:	1 Session Hour = .5 (1/2) Session

As required by law, the information requested must be returned to the Victim Compensation Program (Program) within ten (10) business days and must be provided at no cost to the client, the Program, or local Victim/Witness Assistance Centers. The Program certifies that there is a signed authorization on file for the release of the information requested. Please answer questions fully and complete the signature page at the end of the document. Use additional pages if necessary. Failure to complete this form may result in a delay or denial of payment.

1. Name of Client:	2. Name of Victim:
3. Client's Relationship to Victim:	

4. Name of Therapist:

5. Provider Organization Name:

6. License/Registration Number and Expiration Date:

7. Mark Appropriate Box for Title of Licensed/Registered Therapist (refer to #6)

☐ LMFT	☐ LMFT Intern
☐ LCSW	☐ ASW
☐ Licensed Clinical Psychologist	☐ Registered Psychologist
☐ Psychiatrist	☐ Resident in Psychiatry
☐ Registered Psychological Assistant	☐ Other (Please specify):

8. Name and Title of Supervising Therapist (If applicable):

9. License Number:	10. Expiration Date:

11. What is the client or caretaker's initial description of the crime for which you are providing treatment?

12. What are the client's presenting symptoms/issues (by your observation and client or caretaker's report)?

13. If this victimization was not recent, i.e., within the last 6months, please describe what brought the client into treatment at this time:

14. Please evaluate this client with respect to the criteria in the current **Diagnostic and Statistical Manual of Mental Disorders (DSM).** Evaluate on all 5 axes. Please complete this section as fully and accurately as possible.

Axis I:

Axis II:

Axis III:

Axis IV:

Axis V:

15. **If this client is six years of age or older**, please evaluate him or her on the Social and Occupational Functioning Assessment Scale (SOFAS) that is discussed in the current DSM. (Note: Rate the relational unit in which he or she resided at the time of this report). Score:_____.

☐ Client is under 6 years of age.

Please describe your client's specific behaviors that support this rating:

16. Please evaluate the client on the Global Assessment of Relational Functioning (GARF) scale that is discussed in the current DSM. (Note: Rate the relational unit in which this client resided at the time of this report). Score: _____.

Please provide the basis that supports this rating:

17. If your client has any developmental disabilities, please indicate the nature of the disability and how it might impact the treatment you provide:

☐ No disabilities

18. TREATMENT PLAN

What symptoms/behaviors will be the focus of your treatment? Please list the symptoms/behaviors below and the intervention you plan to use to address each symptom/behavior listed.

1. Symptom/Behavior	Intervention
2. Symptom/Behavior	Intervention
3. Symptom/Behavior	Intervention
4. Symptom/Behavior	Intervention

19. Please describe the interventions you plan to use to address the symptoms/behaviors listed above.

1.

2.

3.

4.

20. Has this treatment plan been discussed with and consented to by the client or the client's caretaker(s)?

☐ Yes ☐ No

21. If this client is a minor, is a primary caretaker(s) involved in the treatment, and if so, what is the nature and extent of that involvement?

☐ Not a minor

22. Please describe any factor(s) not already noted which you believe may have a significant impact on the course of your treatment of this client:

23. Do you plan to use any standardized, objective measures to assess the progress of your client's treatment?

☐ No
☐ Yes. Please specify the tests you expect to use:

24. Please describe why the treatment you are proposing is necessary for the recovery of the direct victim(s):

25. What symptoms/behaviors exhibited by the direct victim will be the focus of your treatment for the derivative victim?

26. What intervention(s) do you plan to address for each of the symptoms/behaviors described above?

27. Please describe the arrangements you have made in coordinating this treatment with the treatment being provided to the direct victim:

28. Is there any additional information to be considered that is not addressed in this Treatment Plan? Please explain:

DECLARATION

CLIENT NAME: _____ CLAIM NUMBER: _____

If the victim's offender is convicted, the Board will request the criminal court to order the offender to pay restitution to reimburse the Board for any expenses the Board has paid for this crime. As a treating therapist you must be prepared to testify in a restitution hearing that the mental health counseling services you provided were necessary as a direct result of the crime at the percentage indicated below. **Please Note:** ***The Board can only pay for the percentage of treatment that is necessary as a direct result of the crime.***

A. In your opinion, what percentage of your treatment is necessary as a direct result of the qualifying crime?

- ☐ 0 %
- ☐ 25%
- ☐ 50%
- ☐ 75%
- ☐ 100%
- ☐ Other: _____%

B. What type of crime is the client being treated for?

☐ Assault With a Deadly Weapon ☐ Domestic Violence ☐ Child Abuse/Molest ☐ Sexual Assault ☐ Robbery
☐ Driving Under the Influence ☐ Hit and Run ☐ Homicide
☐ Other (Do not include any confidential facts in your description of the crime.) _____

I declare under penalty of perjury under the laws of the State of California (Penal Code sections 72, 118, and 129) that: (1) I have read all of the questions contained on this form and, to the best of my information and belief, all my answers are true, correct and complete; and (2) all treatment submitted for reimbursement by the Board or pursuant to this form was necessary at the percentage noted above and as a direct result of the crime described above. I further understand that if I have provided any information that is false, intentionally incomplete or misleading, I may be found liable under *Government Code section 12650* for filing a false claim with the State of California and/or guilty of a misdemeanor or felony, punishable by six months or more in the county jail, up to four years in state prison, and/or fines up to ten thousand dollars ($10,000).

I understand that mental health counseling treatment must be approved in advance. Treatment beyond the client's session limit will not be reimbursed until approved. I understand that if treatment is provided without the required approval, the Program may not reimburse those expenses.

IMPORTANT **– You** MUST **Provide The Required Signature(s) Below**

Treating Therapist:

Name: _____ Lic #: _____
(Please Print Clearly)

Signature: _____ Date: _____

Telephone Number: _____

If Registered Intern:

Supervising Therapist's Name: _____ Lic #: _____
(Please Print Clearly)

Signature: _____ Date: _____

Telephone Number: _____

Tax Identification Number of person or organization in whose name payment is to be made:

_____

If you would like to be contacted by email when possible, please enter your email address below (optional).

_____

Clear Form **Print Form**